Health Reform: Why Now, Why Here, and Some *Big* Choices

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Colorado's Blue Ribbon Commission
For Health Care Reform
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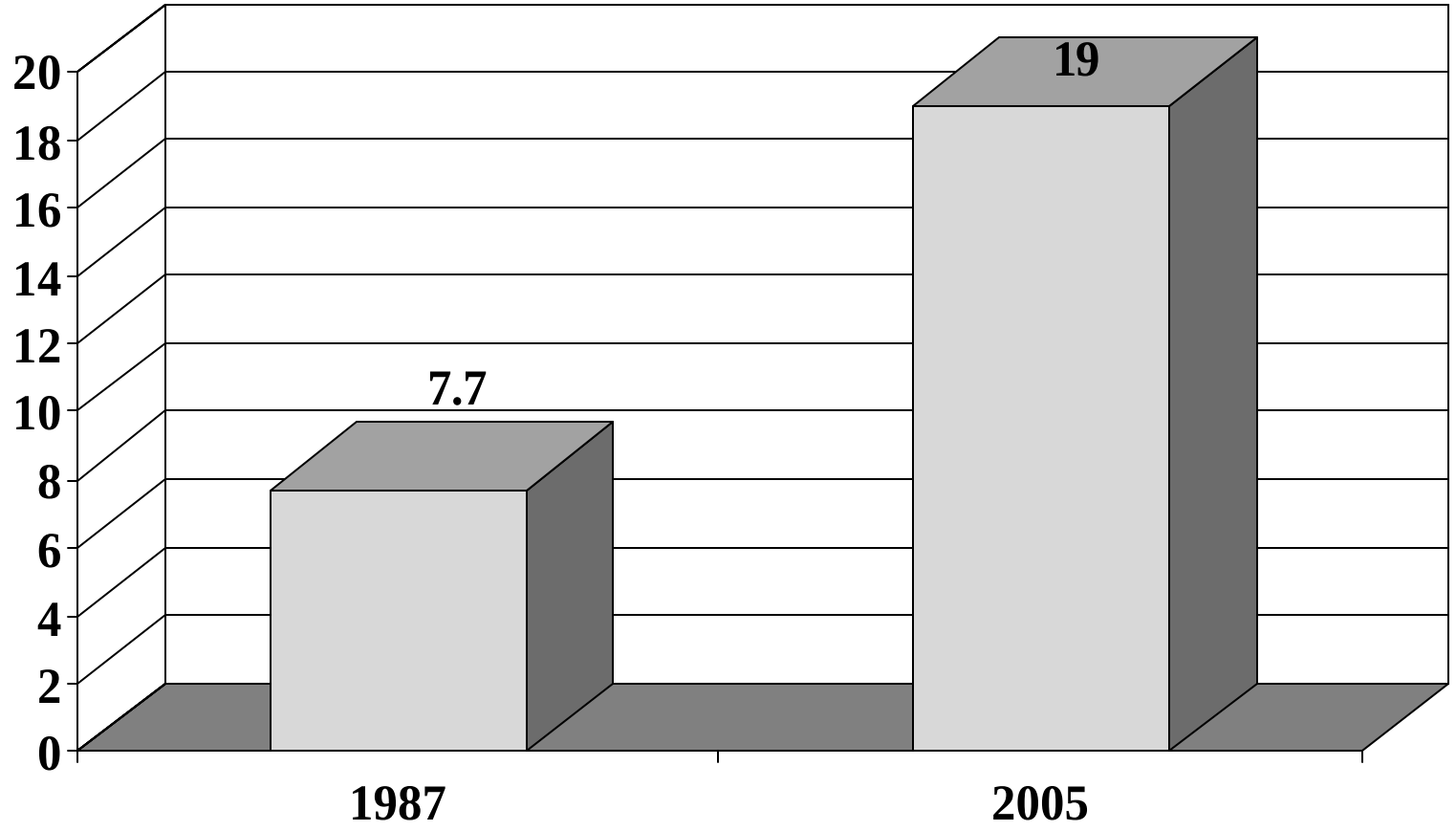
Overview

- Why Now
- Visions Before You
- Some Implications of the Visions
- Specific choices made by some states
- Specific proposals on your table
- Emerging Consensus?
- National Rumblings, Rumors, and campaigns
- Decisions to make

Why Are We Here?

- 3 Health System Problems
  - Low value for dollar
  - Mediocre and uneven quality
  - Inequitable access
- Problems are Serious
- Problems are Linked
- Problems are Festering from Neglect
- Neglect of this set of problems is immoral

Percent of median family income required to buy family health insurance



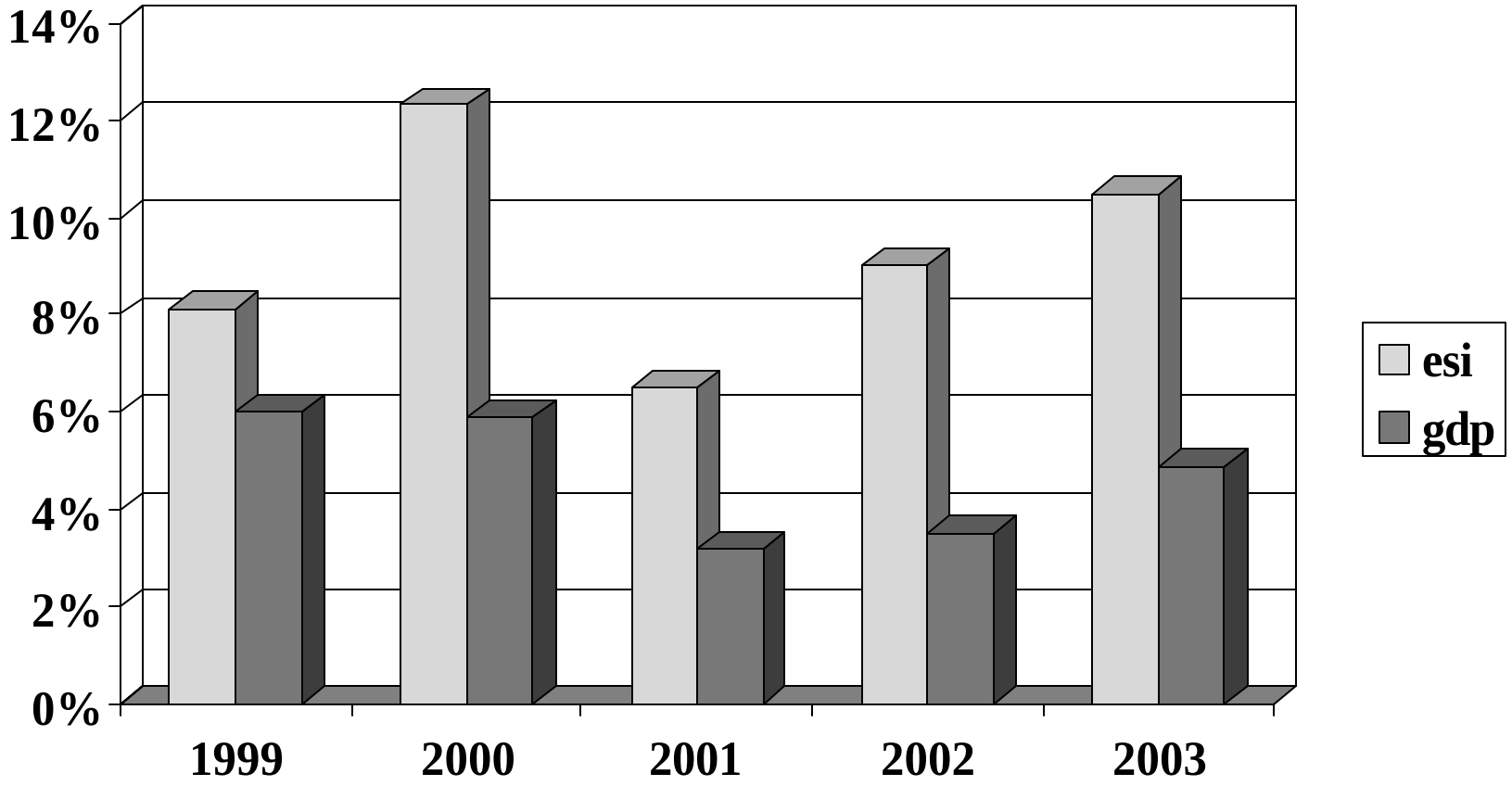
Source: Author's calculations, using KFF and AHRQ premium data, CPS income data.

Labor Market Realities

Occupation	Family premium/Median wage
Physician	**7.9%**
History professor	**14.8%**
Secretary	**30.9%**
Carpenter	**25.6%**
Cook	**50.0%**

Source: KFF premium and BLS wage data, 2004.

Premium Payments v. GDP Growth Rate



Source: NIPA, BEA/Commerce Dept.

Compared to Other Countries

- #1 in spending, share of GDP, per capita
- #37 (by WHO) on overall system performance, next to Slovenia and Costa Rica
  - Life expectancy, child survival, fairness, responsiveness, health outcomes

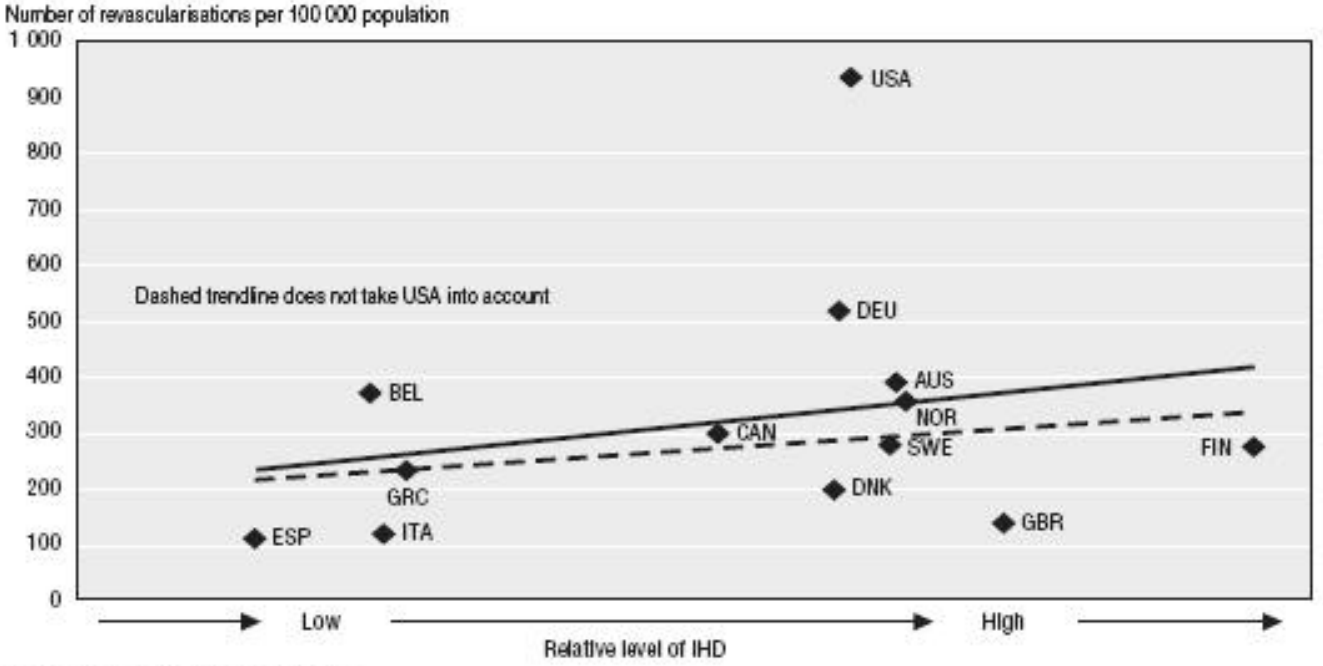
American health care
"gets it right"
54.9%
of the time.

McGlynn EA, Asch SM, Adams J, *et al.* The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348(26):2635-45 (June 26).

Source: Brent James, Intermountain Health Care, Presentation to state legislators, March 24,2007

US Overuses interventionist technological procedures

Figure 2.1. **Utilisation rates of revascularisation procedures and relative level of IHD**



IHD: Ischaemic heart disease.

Note: Age-standardised IHD mortality rates are used as a proxy for relative levels of IHD. Belgium, Australia, Spain (1995); Denmark, Finland, Sweden (1996); Canada, Germany, Greece, United Kingdom, United States (1997); Italy: mortality (1995) and revascularisations (1996); Norway: CABG (1996), PTCA (1998), mortality (1995). Data standardised to the European population aged 40 and over.

Source: Revascularisations: see Table 2.4. IHD mortality: OECD Health Database (2002).

Source: Brent James, Intermountain Health Care, Presentation to state legislators, March 24,2007

Annual Number of Excess Deaths

- Medical Errors in Hospitals: 98,000
- Poor Quality: 42,000-79,000
- Diabetes (for comparison): 73,000

Source: IOM, NCQA, and CDC

Inequitable Access

- Census reduced national estimates from 47m to 45m (770k in Colorado)
- Insurance is key to access
- Insurance is income-related
  - Income < 25k are 25% uninsured
  - Income > 75k are 8% uninsured
- Social Cost is high
  - IOM estimates 18-20k premature deaths yearly
  - IOM says cost of uninsured = cost of subsidies within coverage expansion

Competing Visions

- The Market is Perfect, and freed from current and all regulations, will solve all problems
- The Market is Evil, so Government alone must and can solve all problems
- Health markets are flawed but powerful
  - Public and private forces must align interests and incentives to reach efficiency and Justice

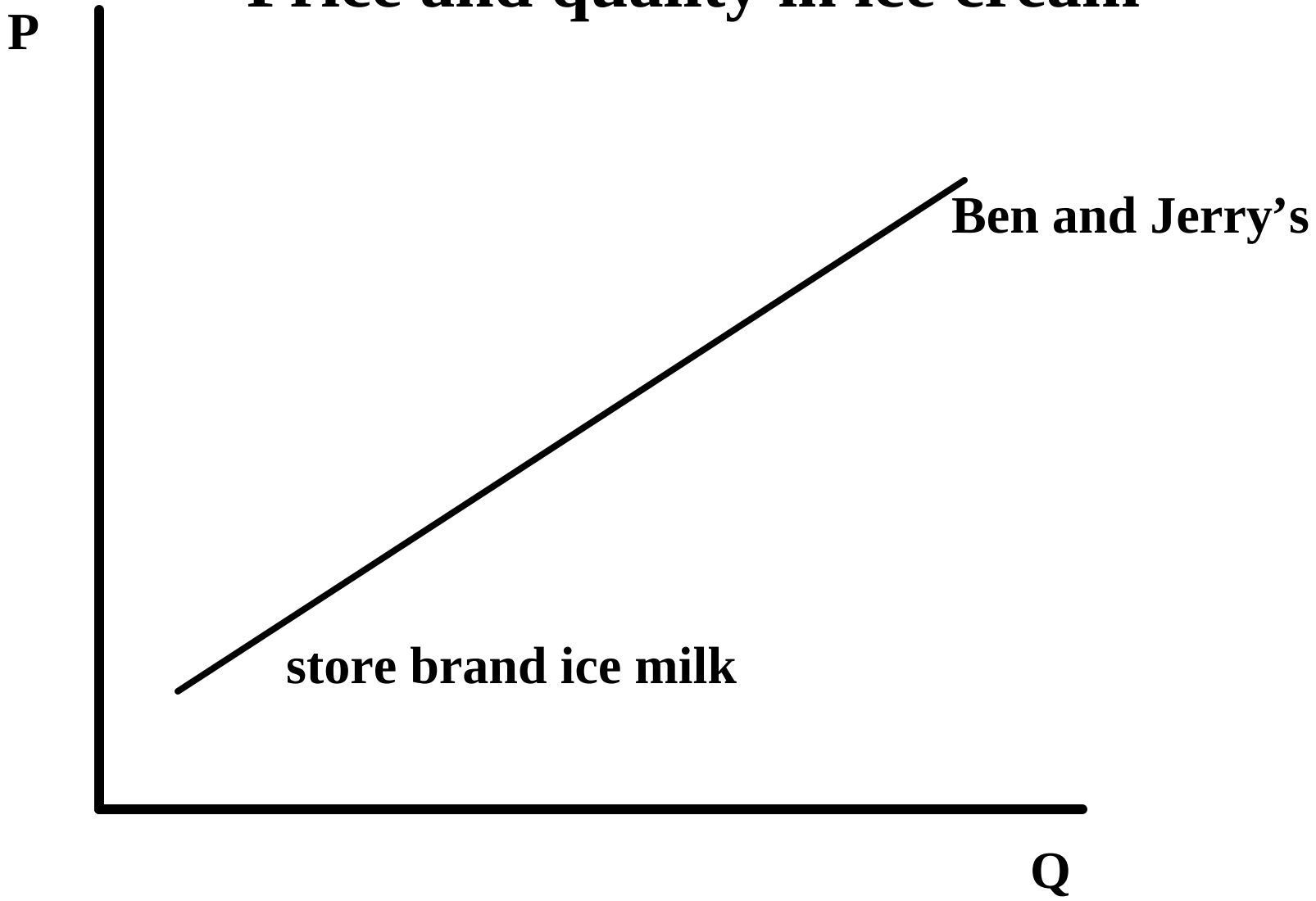
“Pure” Market Solutions

- End insurance regulation
- End benefit mandates
- End government subsidy programs

Competition in Insurance Markets

- Price and Quality
- Standard assumption is P depends on Q
- Quality in HI determined by:
  - services covered/excluded
  - cost-sharing
  - providers' quality, efficiency and prices

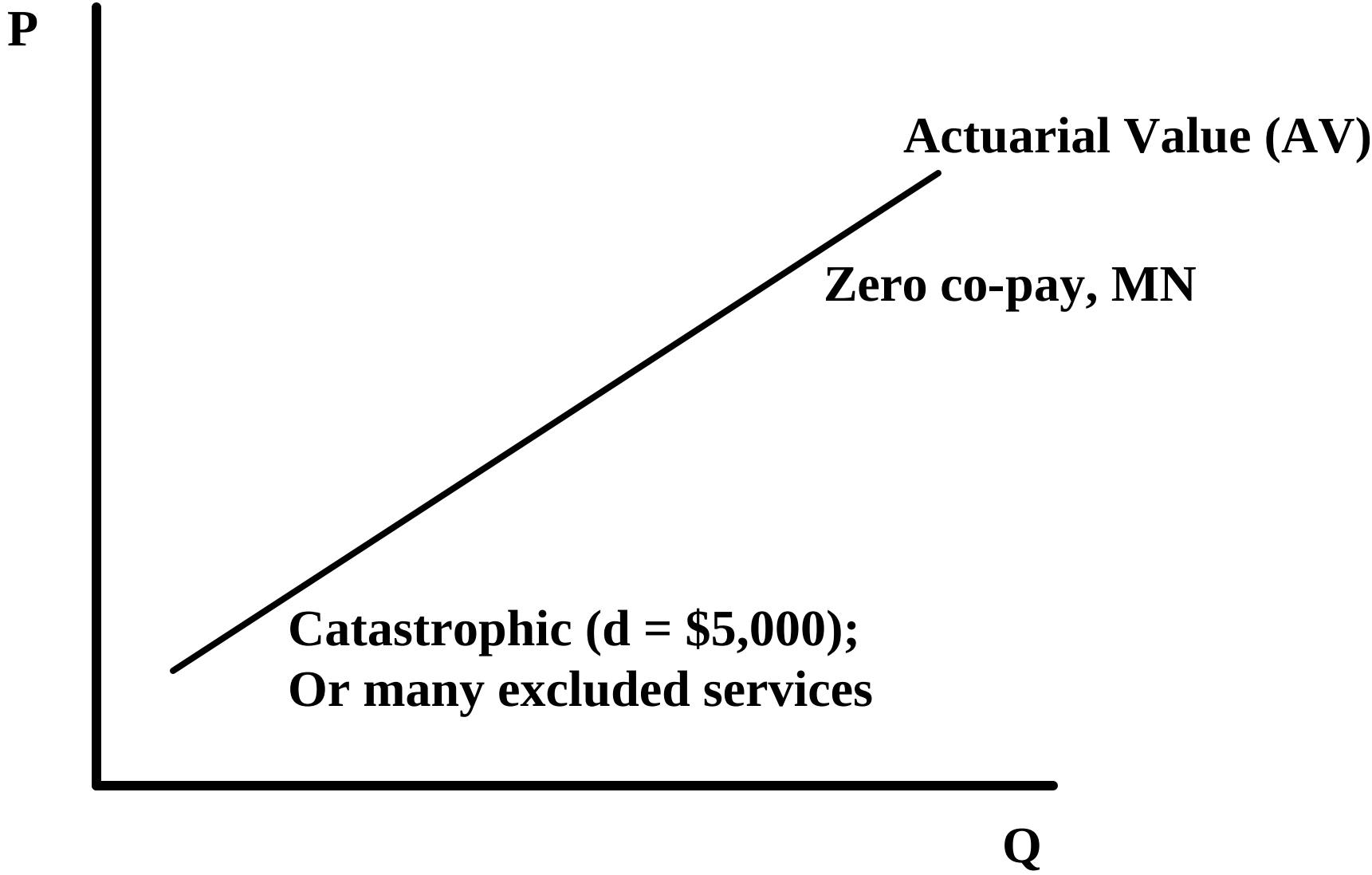
Price and quality in ice cream



Problems with HI Markets

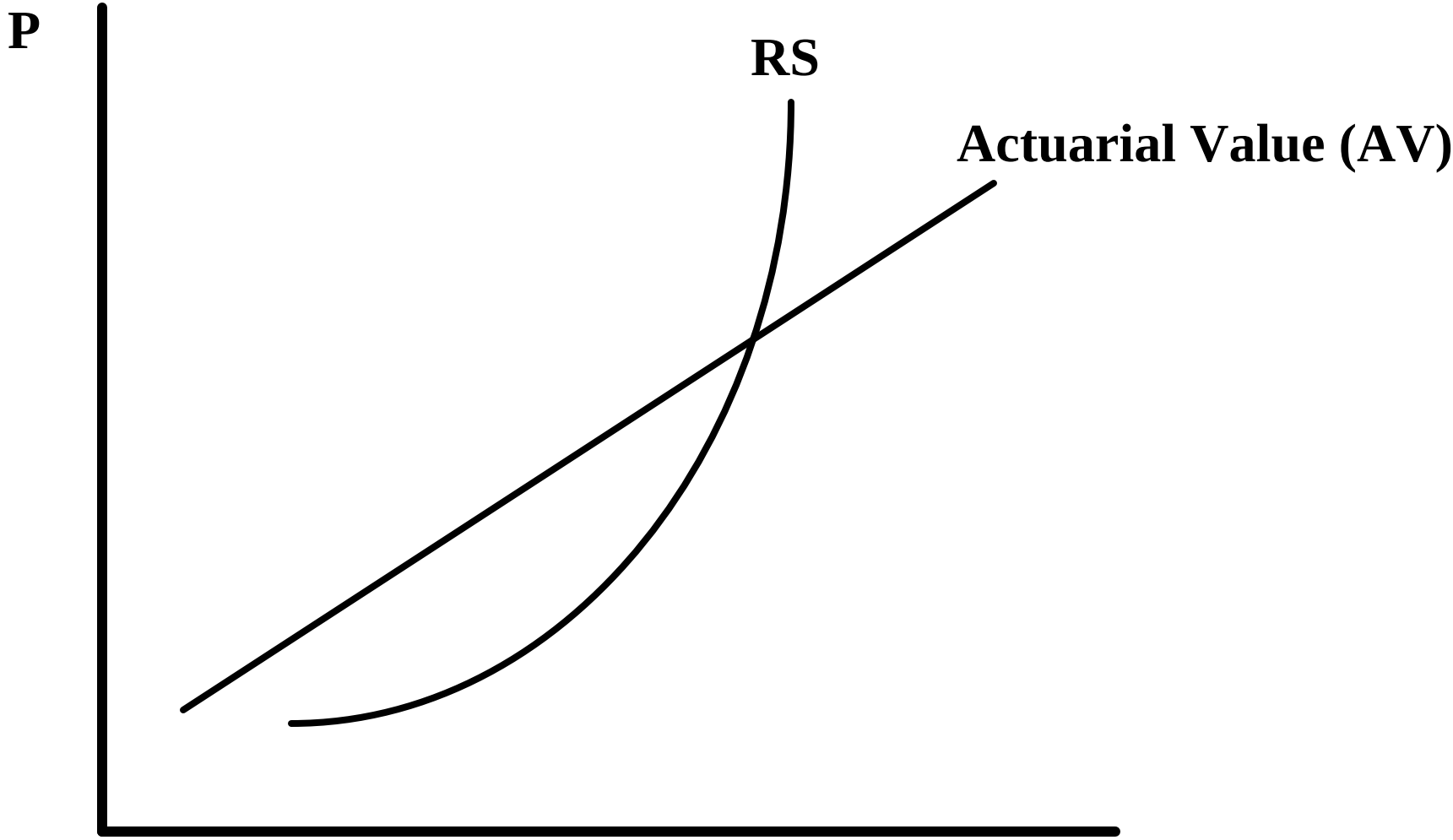
- Price and quality signals are muddied by risk selection
- Risk selection varies with comprehensiveness
- Lower risk prefer lower comprehensiveness, higher risk need/prefer more coverage
- So, Price is also a function of the average risk of enrollees in specific insurance product
- Sellers not always willing to sell to next customer

Price and quality in HI



AV IFF everyone buys each policy

Price and quality in HI



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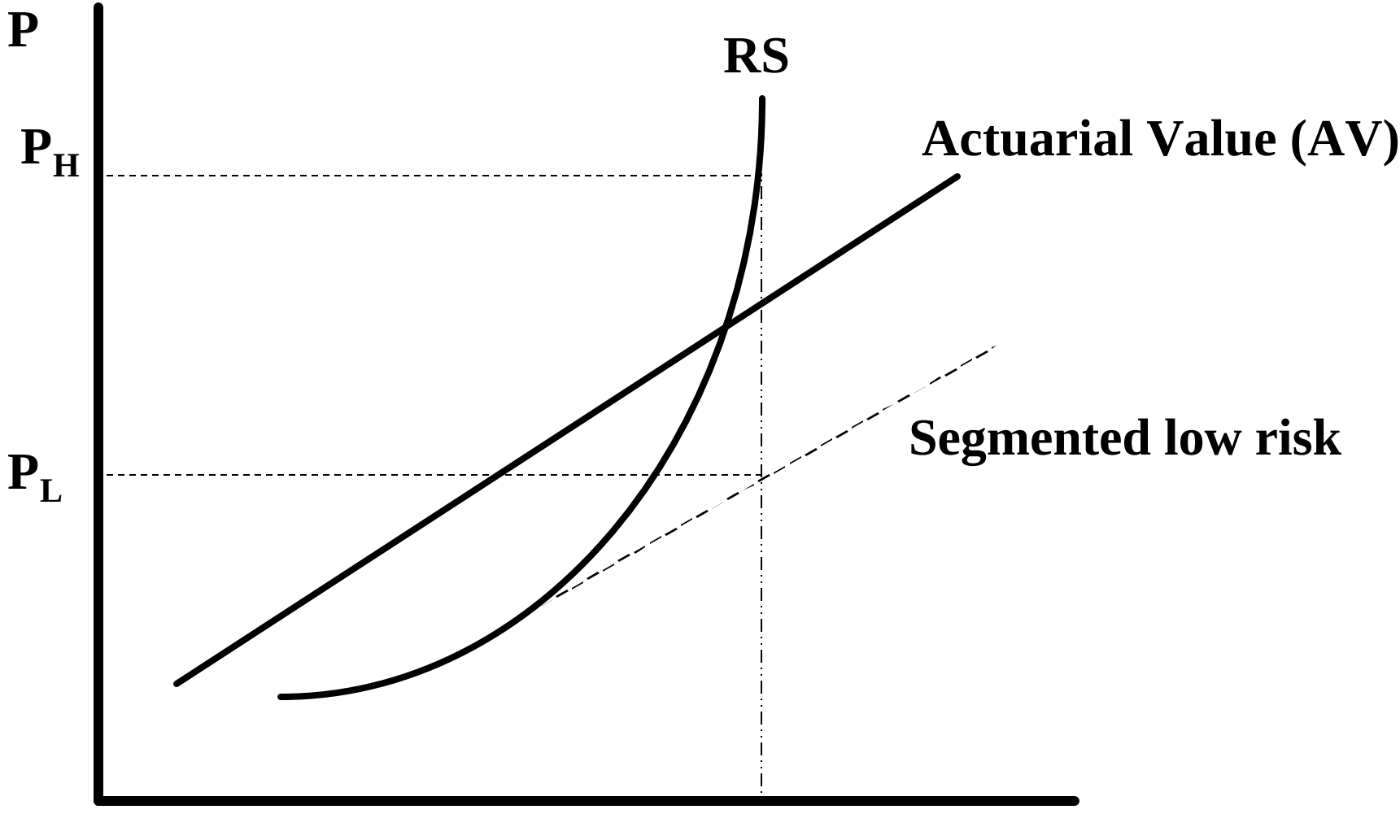

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$P_L < P_H$ if underwriting/pricing variance allowed

Promoting Different Types of Competition in Insurance Markets

- NO regulation: value added for healthy by segmenting/excluding higher risks
  - Maximum product variation
- Heavier regulation: value added mostly through more efficient provider networks, less product variation
- Concept of fairness, priorities differ

What do we know about the non-group market?

- Loads are much higher (15-30%)
- Take-up rate much lower (25% vs. 90%)
- Search costs are high
  - Variance in premium \ benefit offers is large
- It works for some/many/most?
- It cannot work well for seriously ill, low income
- Reforms produce large tradeoffs
- There is market failure in the inability of low risk to find policies offered at prices near their E[c]

Source: Pauly and Nichols, *Health Affairs web exclusive, 10/23/02*

Why State Reforms Passed

- Small business owners were outraged
  - Premium inflation
  - Instability of insurance offers
- Non-group insurance stories are harsh, sad, and true
  - Adverse selection is a real threat
  - Selection management is profitable
  - Insurers do what they are allowed to do
- Insurance industry historically preferred State regulation to Federal

“Pure” Government Solution

- Government becomes sole insurer and payer
- Wholly tax financed
- Technically could work
- Issues
  - Trust?
  - Effectiveness in improving value per dollar?
  - Can major efficiencies be achieved any other way?
  - Philosophy of Solidarity vs. Personal + Shared Responsibility

Recent choices by some states

- Massachusetts, Gov. Schwarzenegger
  - Linked personal and shared responsibility
    - Shared includes making marketplace
    - Shared includes spreading financing burden
    - Shared must address cost growth as well
- Ambitious but cautious
  - VT, IL, PA (all *but* mandates)
- The best they can right now
  - AR, NM, WV
- Commissions + talk
  - WA, OK, MN, NJ, NY

Choices on Your Table

- Better Health Care for Colorado
  - New market + subsidies, public expansion, seamless
- Solutions for a Healthy Colorado
  - Subsidies plus mandate, SBP, new market rules
- A Plan for Covering Coloradans
  - “emerging consensus” plan
- Colorado Health Services Program
  - Thoughtful single payer
    - Quality related payment reforms

Some National Conversations

- Wyden (D-OR) and Bennett (R-UT)
  - Baird (D-WA) and Emerson (R-MO)
- Wal-Mart – SEIU, Wal-Mart – BRT – AARP
- FAH, ERIC
- President Bush
- Presidential Campaigns

Emerging Consensus?

- Personal + Shared Responsibility
  - Personal responsibility for health and insurance
  - Shared responsibility for:
    - Marketplace
    - Subsidies
    - Stewardship of health delivery system
- More Efficient Delivery System
  - Information + Incentives + Comparative Assessment

Decisions Before You

- Is status quo reality and trajectory acceptable?
- Assess power and limits of markets IN COLORADO
  - restructure where necessary
- There is no “Perfect” approach
- Select policies consistent with your willingness to invest Colorado’s resources
- Long run success requires delivery system reform
- Long run success requires community, trust, adaptability and personal + shared responsibility